Psychiatric Crisis from the Perspective of Police Officers: Stigma, Perceptions of Dangerousness, and Social Distance

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Abstract

Stigma, perceptions of dangerousness, and social distance toward individuals with mental illnesses may influence police officers' behaviors and dispositional decisions during routine patrol duties that involve interactions with subjects experiencing a psychiatric crisis. The Crisis Intervention Team (CIT) training program seeks to decrease stigma in officers, while increasing knowledge and improving de-escalation skills and related behaviors. This study examined stigma using two measures—a semantic differential measure comprised of 12 scales and a social distance measure—in a sample of 250 CIT-trained and 332 non-CIT-trained officers who viewed or read vignettes of an individual with psychosis and another with suicidality. The two stigma measures were thus completed twice, each time linked to a vignette. Regarding the semantic differential measure, stigmatizing attitudes were apparent in both groups of officers especially when "yourself" was used as the comparator as opposed to "an average police officer" or "an average person." Such attitudes were particularly apparent in terms of perceived dangerousness pertaining to psychosis. Among the 12 assessed attitudes, perceptions of dangerousness were most strongly correlated with social distance toward the individual with psychosis. CIT-trained officers had lower levels of stigma toward the man in the psychosis vignette (but not the woman in the suicidality vignette) compared to non-CIT-trained officers. Explorations of the rich data suggest that in measuring stigma, using "yourself" rather than "an average person" as the comparator may make stigma more detectable. Furthermore, findings suggest that it may be as useful, and more efficient, to simply measure attitudes toward the person with a mental illness without reference to a comparator. Implications pertaining to stigma-reduction interventions, both among police officers and in a wider societal audience, are discussed.

Key words: Crisis Intervention Team, law enforcement, police, social distance, stigma

Introduction

For individuals with mental illnesses, police officers often serve as first responders to their crisis situations (Lamb, Weinberger, & DeCuir, 2002) and consequently gatekeepers to the mental health and criminal

justice systems (Wells & Schafer, 2006). Approximately 10% of all police contacts involve a person who has a mental illness (Dean, Steadman, Borum, Veysey, & Morrissey, 1999) and up to one-third of individuals seen in emergency mental health services are referred by officers (Borum, Deane, Steadman, & Morrissey, 1998). Recent reports have highlighted the increasing problem of incarceration among those with a mental illness; 40% of persons with mental illnesses have spent time in jail or prison, and 16% of persons in jails or prisons have a mental illness (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010). Influencing factors of officers' decisions to arrest, refer to mental health services, or take no action against a person with a mental illness include severity of the crime (if one is committed), the subject's behavior, the officers' understanding of a subject's circumstances, and stigma held by the officer (Watson, Ottati, Morabito, Draine, Kerr, & Angell, 2010).

Stigma (a mark or attribute that separates and devalues an individual in another's eyes, Major & O'Brien, 2005) toward people with mental illnesses can be observed in frequent negative representations in entertainment and news media (Corrigan, Green, Lundin, Kubiak, & Penn, 2001) and persistent public misperceptions of such individuals as dangerous and unpredictable (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Phelan, Link, Steuve, & Pescosolido, 2000). Results of a number of studies reveal the public's desire for greater social distance from (i.e., being uncomfortable being close to) persons with mental or behavioral disorders, particularly those with substance use disorders and schizophrenia (Jorm & Oh, 2009; Lauber, Nordt, Falcato, & Rossler, 2004). Furthermore, these attitudes may lead to discrimination in life domains important to recovery in mental illness. For example, research suggests that the general public is less likely to lease to or hire someone with a mental illness (Corrigan et al., 2001a). In addition to limiting opportunities, another likely consequence of public stigma for those with a mental illness is internalized stigma, or "self-stigma" surrounding uncertainties of acceptance or rejection by one's community, as well as the delay of initiation of appropriate treatment, which may adversely affect outcomes (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Corrigan et al., 2001a). Although efforts have been implemented to decrease stigma, such as public education depicting mental illnesses as neurobiological conditions, a recent study by Pescosolido and colleagues (2010) suggests that despite this effort, levels of stigma have remained stable, and in some cases have increased (Pescosolido, Martin, Long, Medina, Phelan, & Link, 2010).

It is therefore not surprising that individuals with mental illnesses encounter stigma and discrimination in a variety of life domains, including encounters with police officers. Common content of stigmatizing attitudes relevant to police officers—and potentially influencing their interactions with individuals with mental illnesses—include misperceptions of dangerousness, unpredictability, and incompetence. When examining perceptions of discrimination in a sample of individuals with a mental illness, approximately one-fourth of participants (26.9%) endorsed experiencing discrimination during an encounter with police (Corrigan, Thompson, Lambert, Sangster, Noel, & Campbell, 2003). Examining attitudes of police officers, Watson and colleagues (2004) found that officers perceived a victim as more dangerous and less credible when they had information that he had schizophrenia than when that information was not provided. As law enforcement officers typically serve as first responders, and oftentimes are the only community resource alerted in crisis situations involving a person with a mental illness (Lamb, Weinberger, & Gross, 2004), reducing stigma is crucial. Less stigmatizing attitudes toward people with mental illnesses could facilitate less punitive approaches to resolving encounters. For example, officers with less negative attitudes may be more likely to resolve encounters by referring individuals to mental health treatment facilities, rather than arresting or taking no action, thus reducing unnecessary incarceration of and improving treatment access for affected individuals. Because societal stigma significantly hinders

opportunities for people with mental illnesses (Corrigan et al., 2001a), it is important to further assess stigma, including stigma among police officers, and identify ways to reduce it.

One police-based approach to improving responses to individuals with mental illnesses is the Crisis Intervention Team (CIT) model. The CIT training curriculum, developed through collaboration between the law enforcement, mental health, and advocacy communities, is designed to provide officers with a multi-dimensional look into mental illnesses in an effort to promote jail diversion, improve officer and subject safety, and reduce stigma. According to previous findings, officers report an increased level of confidence in responding to people with mental illnesses and a reduced level of stigma after the training (Compton, Esterberg, McGee, Kotwicki, & Oliva, 2006). Training components such as site visits address two constructs of stigma, social distance and familiarity, by granting officers the opportunity to interact with consumers (i.e., individuals with mental illnesses who make use of mental health treatment services) while not in crisis, which is rarely available to officers during routine patrol duties. The de-escalation role-playing component of CIT training also allows officers to apply the techniques and information learned throughout the training week to better prepare them to effectively handle real encounters post-training. In conjunction with the lecture topics covering the various signs and symptoms of mental illnesses, substance abuse, and developmental disabilities, these training components familiarize officers with the realities of living with a serious mental illness and how it impacts consumers, their families, and the surrounding community. Taken together, CIT training is designed to give participating officers a better understanding of the importance of their role as first responders so as to improve the likelihood that individuals with mental illnesses will safely and respectfully receive the treatment they need.

The current study examined levels of stigma toward subjects experiencing psychiatric crises among CIT-trained and non-CIT-trained officers across the state of Georgia. The authors hypothesized that: (1) CIT-trained officers would have less stigmatizing attitudes than non-CIT-trained officers, and (2) stigmatizing attitudes, especially perceptions of dangerousness, would be significantly correlated with social distance. Given the richness of the information collected, data were further explored in an effort to inform future measurement of stigma amongst police officers and in the general population.

Methods

The sample of 582 officers was recruited from six police departments throughout the state of Georgia as part of a larger study examining officer-level effects (e.g., knowledge, attitudes, stigma, self-efficacy, de-escalation skills, and referral decisions) of CIT training. Both CIT-trained and non-CIT-trained officers were invited to participate in the study through announcements at roll calls and department functions, word of mouth, posting of flyers, and e-mail invitations by the research team. Participating officers took the self-administered, 3-hour survey in groups comprised of 6–29 officers. Before taking the survey, a member of the research team presented the informed consent document in detail, allowing time for questions from participants. The research protocol and informed consent processes were approved by the university's institutional review board.

For the current study, stigma toward individuals with a mental illness was assessed using two vignettes, one of which was viewed as a video and the other read in a script format. One vignette depicted a subject, David, who was an African American male who an officer responded to after a call about a disturbance on private property. In the vignette, David was psychotic and displayed signs of delusions, hallucinations, and agitation (herein, this vignette is referred to as the "psychosis vignette"). The second

vignette focused on Susan, an African American female who an officer responded to after a call of suicidal threats. During the vignette, Susan endorsed thoughts and threats of suicide and was intoxicated on alcohol (this vignette is hereafter called the "suicidality vignette"). In each assessment group, one vignette was viewed as a video and the other was read privately by officers, which was randomly varied across assessments in order to test the effects of presentation format. (The two different modes of presentation did not appear to be associated with meaningful differences in responses (Compton et al., unpublished data); thus we did not include presentation format in this analysis.) Data from a prior vignette study suggested that race and gender of the vignette subject did not have significant effects on social distance scores and other stigma measures (Compton et al., unpublished data). Therefore, subject race and gender were not varied in this study. Further, when respondents' race and gender were considered, significant interactions were not observed. As a result, race and gender effects were not considered further in the current analysis of stigma and social distance.

Stigma was measured using a semantic differential measure (SDM) first utilized by Nunnally (1961) and Olmstead and Durham (1976) to measure attitudes in the general population toward individuals with mental illnesses. As a means of measuring stereotyping related to labeling (Link, Yang, Phelan, & Collins, 2004), SDM measures have illustrated negative public attitudes toward those with mental illnesses, especially schizophrenia, substance use disorders, and severe depression (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). The measure contained twelve single-item scales examining 5 dimensions. Each of these dimensions represents a characteristic that an individual might use to assess the safety of an unknown other: (1) understandability (predictable–unpredictable), (2) complexity (simple–complicated), (3) potency (strong–weak and rugged–delicate), (4) activity (warm–cold and fast–slow), and (5) evaluation (valuable–worthless, clean–dirty, sincere–insincere, safe–dangerous, wise–foolish, and relaxed–tense) (Olmsted & Durham, 1976; Nunnally, 1961; Nunnally & Kittross, 1958). Instead of contrasting scores pertaining to "a person with mental illness" with a comparator, as done in previous research, participants were asked to separately rate the 12 SDM scales in relation to the vignette subjects, David and Susan. Comparators used in this study were "an average person" (as used in prior studies involving this SDM), but also "an average police officer" and "yourself." That is, officers rated, prior to viewing/reading the vignettes and rating David (psychosis) and Susan (suicidality) these three comparators using the 12 scales. All 12 SDM scale scores ranged 1–7, with higher scores indicating more positive attitudes (e.g., 1=Worthless, 7=Valuable).

In this study, SDM scores were calculated in two different ways. First, when SDM scores for a single individual (i.e., David, Susan, an average person, an average police officer, and yourself) are presented, the construct is referred to as "negative attitudes." Thus, for each of these individuals, 12 negative attitude scores can be generated, as well as a "total negative attitudes" score that sums the 12 scale scores pertaining to that individual. In this scoring of single individuals, lower scores indicate more negative attitudes. Second, the construct of "stigma" refers in this report to negative attitudes toward David or Susan *in relation to* one of the three comparators. Thus, scores on stigmatizing attitudes toward someone with psychosis (David) or suicidality (Susan) were derived by subtracting the vignette-associated SDM scale scores from corresponding scores for "an average person," "an average police officer," and "yourself" comparators. In doing so, when the SDM scale scores are calculated to reflect negative attitudes toward David or Susan in relation to one of the comparators, higher scores indicate a larger mean difference, or greater stigma toward the vignette subject, David or Susan. Additionally, "overall stigma scores" (summing the differences across all 12 scales) were calculated in relation to psychosis and suicidality.

A second measure of stigma, an adapted version of the Social Distance Scale (SDS; Bogardus, 1925), was used to test desired social distance held by officers toward each vignette subject. The scale consisted of 9 items, rated on a four-point Likert scale (1=very willing, 4=very unwilling). Therefore, total scores ranged 9–36, with higher scores indicative of a higher level of stigma or desired social distance. An example of a question is, “Six months from now, when David is not in crisis, how willing would you be to live next door to him?” For the current study, the SDS was adapted to state, “Six months from now, when David (or Susan) is not in crisis, how willing would you be..." This wording was chosen in recognition of the acute crisis situation involving these two subjects. It was thought that an extended time period needed to be presented to capture stigma toward the persistent psychiatric condition rather than an expected or even valid reaction of respondents to the acute crisis situation.

All variables of interest were examined for distribution and variability, and socio-demographic variables were summarized. Independent samples Student’s *t*-tests were used to examine differences between scores of CIT-trained and non-CIT-trained officers. All correlations were calculated using the Pearson product-moment correlation coefficient. Analyses were conducted using the *SPSS 17.0* statistical software, and all tests were 2-tailed with the criterion for significance set at $p \leq 0.05$.

Results

Sample characteristics

Participants were, on average, 37.0 years of age ($\pm$8.7), had attended some college (14.3$\pm$1.8 years of education), and had served as a police officer for 10.1 years ($\pm$7.7). The majority of the sample was male (472, 80.5%), White/Caucasian (356, 60.8%), non-Hispanic (553, 96.5%), married or living with a partner (378, 64.5%), and reported an annual household income of greater than $60,000 (313, 53.4%). Among 582 officers (from an overall sample of 586 participants) for whom CIT status was identified, 250 (43.0%) had completed CIT training and 332 (57.0%) were not CIT-trained.

Hypothesis 1: CIT-trained officers have less stigmatizing attitudes than non-CIT-trained officers

Stigmatizing attitudes toward psychosis and suicidality were first examined against the comparators. Positive mean differences indicated stigma toward the psychotic man and suicidal woman portrayed in the vignettes, and differences ≥1.5 were deemed a priori to be meaningful stigmatizing attitudes (in light of the 1-7 rating scale) for ease of interpretation. Overall, stigma scores were higher in relation to the psychosis vignette (**Table 1**) than the suicidality vignette (**Table 2**). These two tables show that stigmatizing attitudes become more readily detectable as the comparator is changed from “an average person” to “an average police officer” to “yourself.” Furthermore, both CIT-trained and non-CIT-trained groups showed the highest stigma scores on the dangerousness domain when compared with “yourself” (difference scores of 2.65–3.52) for both vignettes (**Table 1, Table 2**). Scores pertaining to dangerousness are also depicted in **Figure 1**, which again shows the more observable stigma as the comparator changes.

To statistically examine differences in stigmatizing attitudes between CIT-trained and non-CIT-trained officers, an overall stigma score was calculated by summing differences across all 12 semantic differential scales (**Table 3**). CIT-trained officers had significantly lower stigma (15.01$\pm$11.10) than non-CIT-trained officers (17.20$\pm$11.74) in terms of stigma toward the psychotic man in relation to “an average police

officer" (*t*=2.26, *df*=580, *p*=0.024). Similarly, CIT-trained officers showed significantly lower stigma (21.60±10.61) than non-CIT-trained officers (24.27±11.48) with regard to stigma toward the psychotic man in relation to "yourself" (*t*=2.78, *df*=579, *p*=0.006). The two groups' stigma scores did not differ in comparisons pertaining to the suicidal woman (Susan).

Hypothesis 2: Stigmatizing attitudes, especially perceptions of dangerousness, are significantly correlated with social distance

As shown in **Table 4**, greater stigmatizing attitudes as measured with the various SDM scales correlated significantly with police officers' desired social distance. All attitudinal domains except "rugged–delicate" correlated significantly with social distance scores pertaining to the psychosis vignette (*r*=-0.19 to *r*=-0.52). Similarly, all domains except "rugged–delicate" and "simple–complicated" correlated with social distance scores in relation to the suicidality vignette (*r*=-0.12 to *r*=-0.38). A scatterplot depicting SDS scores in relation to dangerousness scores pertaining to the psychosis vignette is shown in **Figure 2**.

Exploratory analyses: measurement issues pertaining to the SDM

To further examine the various scores available from this study's in-depth, complex use of the SDM measure, "total negative attitude scores" derived in relation to the psychosis and suicidality vignettes were secondarily explored, without reference to a comparator. (In these results, "total negative attitudes" is used rather than "overall stigma score" since the vignette-based responses are not evaluated in relation to a comparator such as "an average person"). Of note, when using these total negative attitude scores alone, greater scores indicate more positive attitudes. Overall, police officers reported more negative attitudes toward an average person (4.4±0.7), than toward an average police officer (4.9±0.7), and themselves (5.5±0.6). **Table 5** shows correlations between these total negative attitude scores (pertaining to "an average person," "an average police officer," and "yourself") in relation to negative attitudes related to the psychosis and suicidality vignettes. The correlations between negative attitudes toward a person with psychosis and negative attitudes toward oneself (and toward an average police officer) were very low (*r*=0.10), though this correlation increased (*r*=0.25) when examining total negative attitudes toward a person with psychosis and negative attitudes toward an average person. Similarly, total stigmatizing attitudes toward a person with suicidality was most strongly correlated with total negative attitude toward an average person (*r*=0.21).

Further, correlations between total negative attitude scores in relation to the psychosis and suicidality vignettes and overall stigma scores as discussed above, were assessed (**Table 5**). As expected, the correlation coefficients increased in a step-wise fashion when assessing associations between total negative attitudes toward a person with psychosis and: (1) total stigmatizing attitudes toward a person with psychosis in relation to an average person (*r*=-0.64), (2) total stigmatizing attitudes toward a person with psychosis in relation to an average police officer (*r*=-0.71), and (3) total stigmatizing attitudes toward a person with psychosis in relation to oneself (*r*=-0.75). Of note, these correlation coefficients are negative because higher total negative attitude scores indicate more positive attitudes, whereas higher differences indicate greater stigma. Correlations pertaining to the suicidality vignette followed a similar trend, again as shown in **Table 5**.

Discussion

As suggested by previous research (Watson, Corrigan, & Ottati, 2004), overall, officers regard persons with mental illnesses as dangerous and unpredictable, and hold higher stigma toward subjects with psychosis than toward the non-psychotic person in crisis. However, CIT-trained officers had significantly lower stigmatizing attitudes toward psychosis than non-CIT –trained officers. While it could be that officers who self-select into CIT have less stigmatizing attitudes to start with, a past focus group study with trained officers revealed that through the training, they gain knowledge that aids in the identification of personally held stereotypes and stigma (Hanafi, Bahora, Demir, & Compton, 2008). Reduction of stigma in officers is crucial as it may lead to improved communication skills and use of de-escalation techniques, thereby lowering the likelihood of using physical force, which would improve outcomes in terms of patient and officer safety, while potentially reducing incarcerations (Compton et al., 2006). More positive experiences with law enforcement and referral to treatment services may also have positive effects on patient outcomes, both immediately (e.g., agitation, engagement) and in the longer term (e.g., symptom severity, adherence).

A number of informative findings emerged from this study of stigma, perceptions of dangerousness, and social distance toward individuals in psychiatric crisis from the perspective of police officers. First, some of the attitudinal domains were more apparent as areas of potential stigma (e.g., dangerousness, unpredictability, tension) than others (e.g., worthlessness, coldness, slowness). Second, both CIT-trained and non-CIT-trained officers reported a greater degree of stigmatizing attitudes with reference to the man with psychosis compared with the woman with alcohol intoxication and suicidality. Third, in partial support of our first hypothesis, significant differences between the two types of officers were apparent, but only with respect to the psychosis vignette when “an average police officer” or “yourself” were used as the comparators. Fourth, some domains among the 12 studied were more strongly correlated with social distance (e.g., dangerousness, which was our second hypothesis) than others (e.g., slowness, delicateness). Fifth, correlations between the domains and social distance appeared to be stronger with regard to the psychosis vignette than the suicidality vignette. Sixth, of potential methodological importance for future studies on stigma, potentially stigmatizing attitudes become more apparent when “an average police officer,” and even more so when “yourself” is used as the comparator rather than “an average person.” Finally, it may be as useful, and more efficient, to simply measure negative attitudes toward the portrayed person with a mental illness without using a comparator and generating a difference score. Taken together, these findings have potential programmatic relevance and implications for police officer training programs such as CIT, and perhaps for broader populations.

The perception of a person with psychosis as dangerous would be crucial to address in the law enforcement community as it was substantially correlated with desired social distance, which in turn reduces the opportunity for establishing trust and rapport. In addition, interventions focused on decreasing stigma toward psychosis in general are warranted. CIT training is one way to reduce stigma in officers. However, while CIT training appears to be effective for reducing stigma, shorter types of intervention may be more practical and efficient to implement across multiple departments. In light of past literature (Corrigan et al., 2001a, Corrigan et al., 2001b; Holmes, Corrigan, Williams, Garbin, & Sullivan, 1999; Link & Cullen, 1986; Penn, Guyman, Daily, Spaulding, Garbin, & Sullivan, 1994), exposure to and familiarity with persons with mental illnesses would be one way to reduce negative perceptions. Presentations by persons with mental illnesses currently in recovery recounting past crisis situations that involved police officers may be effective, and would allow officers to interact with the individuals in an

active learning style, which is the preferred method of learning among police officers (Husbands et al., 2011; Oliva & Compton, 2010). Also, brief in-service training could be offered surrounding psychosis, which could include open dialogues between officers and mental health professionals on past experiences with affected individuals.

Further evaluation of which facets of the CIT training week (e.g., lectures, site visits, or role-play scenarios) are most effective at reducing stigma in officers would better inform focused interventions. Is familiarity with persons with a mental illness through site visits or discussions of consumers' experiences most effective? Or does the experience of role-playing de-escalation techniques prove most useful at increasing self-efficacy while reducing stigma? Answers to such questions would prove useful for the wider law enforcement community and inform intervention strategies.

From a methodological/measurement perspective, it would appear be most useful to use "yourself" as the comparator so that stigma becomes more apparent or detectable. However, it could be argued that "an average person" might be the most relevant comparison for police officers as it allows a consideration of attitudes toward persons with mental illnesses versus other persons they encounter in the line of duty. However, given the high correlation (r=.75–.76) between total negative attitude scores and the stigma scores derived using "yourself," it may be more efficient to simply use the SDM scales without reference to a comparator. This is contrary to the notion that a more accurate measurement of stigma, when utilizing an SDM, will only be elicited when the participant is presented with a "normal" comparator to weigh their attitudes against (Olmsted & Durham, 1976; Nunnally, 1961; Nunnally & Kittross, 1958, Link, Yang, Phelan, & Collins, 2004).

Certain limitations must be acknowledged. First, the generalizability of the findings may be limited by the fact that the sample was drawn from one state in the southeastern United States. However, given the diversity of the six police departments from which officers were drawn (in urban, suburban, and rural departments), this potential limitation may not be substantial. Second, responses may have been influenced by a possible inclination to answer in a socially desirable way. Yet, social desirability bias was unlikely to have had a differential influence between CIT-trained and non-CIT-trained officers, or between the psychosis vignette and the suicidality vignette. Third, the adjective choices in the SDM may have presented a limitation given that they were borrowed directly from a previous study and not tailored to this specific sample. Alternative word choices may have elicited different responses from the officers. Fourth, only psychosis and suicidality were explored in this study, though police officers encounter a broader range of symptoms and disorders during routine patrol.

The current study's examination of stigma in both CIT-trained and non-CIT-trained officers revealed stigmatizing attitudes held across participants, especially related to psychosis. CIT-trained officers endorsed significantly lesser stigmatizing attitudes toward the subject with psychosis. Interventions aimed at reducing perceptions of dangerousness in addition to ongoing CIT training are needed as this attribute was highly correlated to desired social distance in the present sample. Further examination of the CIT curriculum, in terms of which parts are most effective at reducing stigma, would inform future interventions.

Police officers were the subject of the present study because of its overarching focus on CIT training, and the potential importance of stigma in the daily work of officers, which is characterized in part by difficult decisions around arrest, referral to services, or other dispositional outcomes. Ongoing research on

stigma, and the measurement of stigma, should focus not only on law enforcement, but diverse other sectors within society.

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Table 1: Potentially Stigmatizing Attitudes toward the Psychotic Man (David), by CIT-Trained versus Non-CIT-Trained Officer Status and by Comparator (Scores ≥1.50 in shaded cells.)

	CIT-Trained Officers (*n*=250)				**Non-CIT-Trained Officers (*n*=332)**		
	Comparator:				**Comparator:**		
	Average person	*Average police officer*	*Yourself*		*Average person*	*Average police officer*	*Yourself*
Worthless–Valuable	0.59	0.90	1.35		0.79	1.17	1.56
Dirty–Clean	1.12	1.65	2.45		1.28	2.00	2.76
Insincere–Sincere	-0.24	0.16	1.32		0.04	0.62	1.72
Dangerous–Safe	1.67	2.60	3.20		1.89	2.93	3.52
Cold–Warm	0.82	0.43	1.70		0.82	0.51	1.66
Foolish–Wise	0.50	1.27	2.04		0.57	1.58	2.26
Slow–Fast	0.04	0.77	1.10		0.20	0.98	1.34
Weak–Strong	-0.11	0.91	1.33		-0.04	0.97	1.44
Delicate–Rugged	-0.43	0.64	0.42		-0.36	0.78	0.82
Unpredictable–Predictable	2.16	2.74	2.30		1.98	2.77	2.42
Tense–Relaxed	1.96	1.52	2.61		1.98	1.60	2.80
Complicated–Simplified	1.72	1.46	1.90		1.62	1.30	1.99

Table 2: Potentially Stigmatizing Attitudes toward the Suicidal Woman (Susan), by CIT-Trained versus Non-CIT-Trained Officer Status and by Comparator (Scores ≥1.50 in shaded cells.)

	CIT-Trained Officers (*n*=250)				Non-CIT-Trained Officers (*n*=332)		
	Comparator:				Comparator:		
	Average person	*Average police officer*	*Yourself*		*Average person*	*Average police officer*	*Yourself*
Worthless–Valuable	0.14	0.47	0.90		0.17	0.55	0.93
Dirty–Clean	-0.00	0.54	1.32		-0.00	0.71	1.47
Insincere–Sincere	-0.71	-0.29	0.85		-0.73	-0.14	0.96
Dangerous–Safe	1.14	2.06	2.65		1.05	2.08	2.68
Cold–Warm	0.03	-0.36	0.90		-0.06	-0.37	0.75
Foolish–Wise	0.65	1.45	2.20		0.57	1.57	2.25
Slow–Fast	0.15	0.87	1.18		0.28	1.06	1.43
Weak–Strong	1.10	2.13	2.54		1.03	2.04	2.51
Delicate–Rugged	1.16	2.23	2.03		1.20	2.35	2.38
Unpredictable–Predictable	1.50	2.08	1.59		1.22	1.99	1.65
Tense–Relaxed	1.60	1.16	2.24		1.54	1.13	2.33
Complicated–Simplified	1.04	0.80	1.22		1.15	0.83	1.51

Table 3: Comparisons of Stigma Scores in CIT-Trained and Non-CIT-Trained Groups			
	CIT-Trained *n* *mean±SD*	**Non-CIT-Trained** *n* *mean±SD*	**Independent samples** ***t*-test statistic, *df*, *p***
Average person minus person with psychosis	250 9.80±10.00	331 10.77±12.05	*t*=1.03, *df*=579, *p*=0.303
Average police officer minus person with psychosis	250 15.01±11.1	332 17.20±11.74	*t*=2.26, *df*=580, *p*=0.024
Yourself minus person with psychosis	250 21.60±10.61	331 24.27±11.48	*t*=2.78, *df*=579, *p*=0.006
Average person minus person with suicidality	244 7.78±10.93	328 7.40±11.80	*t*=0.40, *df*=570, *p*=0.692
Average police officer minus person with suicidality	244 13.11±11.65	329 13.77±11.86	*t*=0.66, *df*=571, *p*=0.507
Yourself minus person with suicidality	244 19.61±11.31	328 20.82±11.43	*t*=1.27, *df*=570, *p*=0.206

Table 4: Pearson Correlations between Negative Attitudes and Social Distance Pertaining to Psychosis and Suicidality

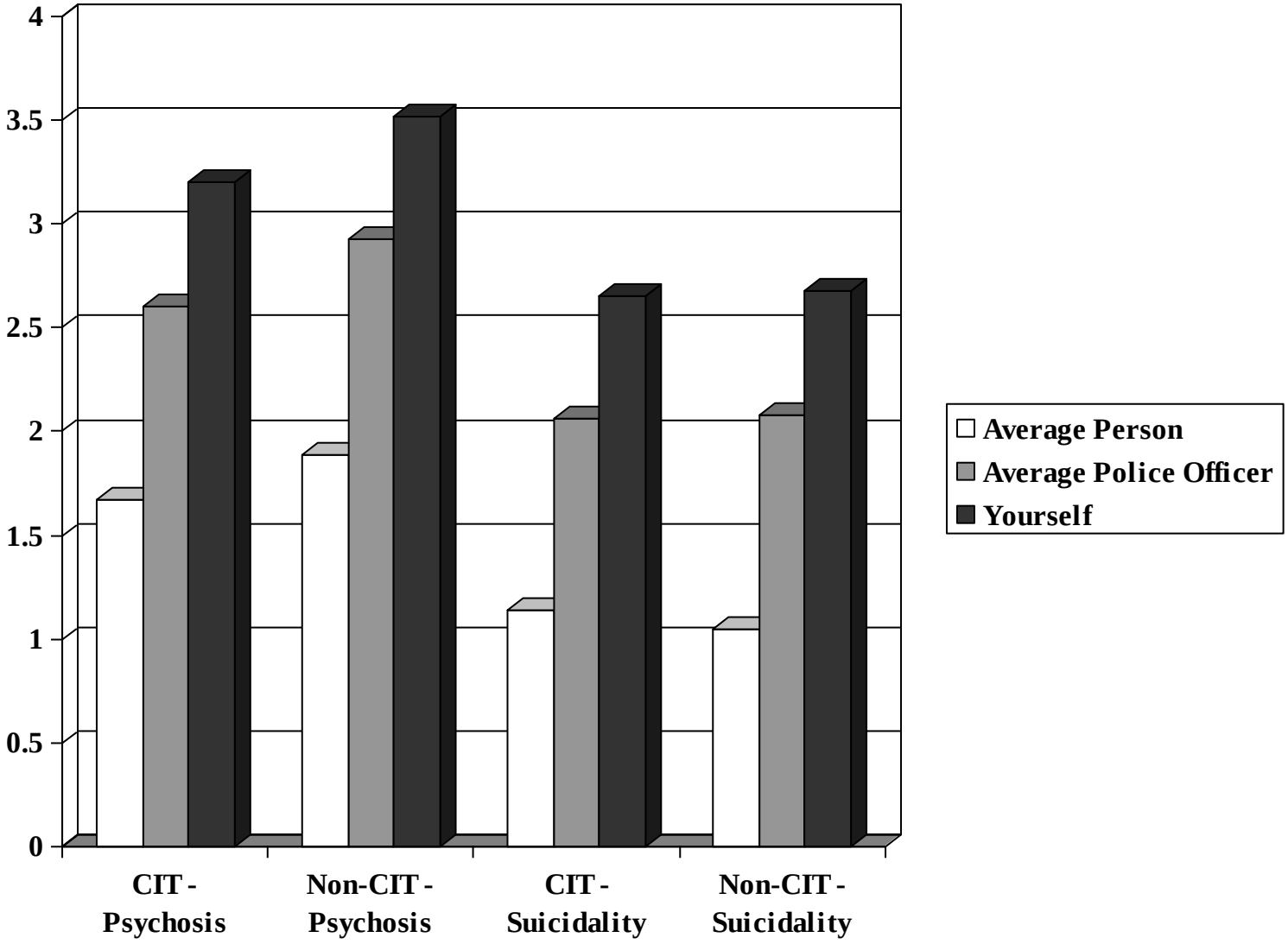
Attitude Scale	Social Distance in Relation to the Psychosis Vignette	Social Distance in Relation to the Suicidality Vignette
Worthless–Valuable	-0.45*	-0.38*
Dirty–Clean	-0.42*	-0.36*
Insincere–Sincere	-0.38*	-0.34*
Dangerous–Safe	-0.52*	-0.35*
Cold–Warm	-0.36*	-0.28*
Foolish–Wise	-0.40*	-0.26*
Slow–Fast	-0.25*	-0.18*
Weak–Strong	-0.19*	-0.22*
Delicate–Rugged	-0.03	-0.03
Unpredictable–Predictable	-0.28*	-0.16*
Tense–Relaxed	-0.21*	-0.12*
Complicated–Simplified	-0.19*	-0.07

*$p \leq 0.01$

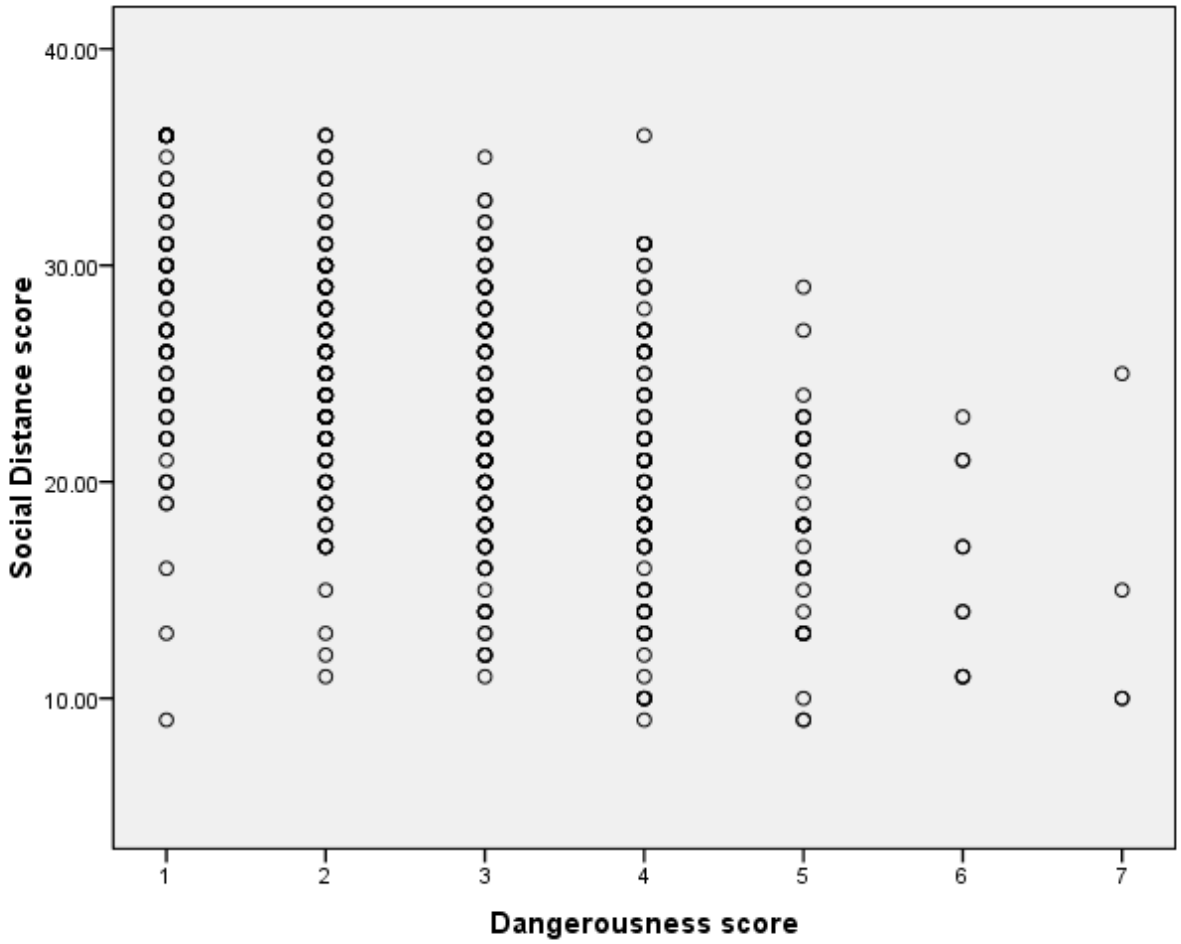
Table 5: Correlations among Various Scores Derived from the SDM Measure		
	Total negative attitudes toward person with psychosis	Total negative attitudes toward person with suicidality
Negative attitude scores not in relation to a comparator:		
Total negative attitudes toward an average person	0.25	0.21
Total negative attitudes toward an average police officer	0.10	0.11
Total negative attitudes toward self	0.10	0.12
Stigma scores in relation to various comparators:		
Average person minus person with psychosis	-0.64	-
Average police officer minus person with psychosis	-0.71	-
Yourself minus person with psychosis	-0.75	-
Average person minus person with suicidality	-	-0.68
Average police officer minus person with suicidality	-	-0.73
Yourself minus person with suicidality	-	-0.76

*All correlations are significant at $p \leq 0.05$

Figure 1: Mean Difference Scores for the Dangerousness Scale of the SDM, by CIT-Trained and Non-CIT-Trained Officer Status, by Psychosis versus Suicidality Vignette, and by Comparator Format



<u>Figure 2</u>: Scatterplot of Scores on Social Distance and Perceptions of Dangerousness (Lower Scores Indicating Greater Perceived Dangerousness) Pertaining to the Psychosis Vignette



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Each year, over two million young people come into contact with juvenile justice systems, including hundreds of thousands entering detention facilities. Arrest, court hearings, probation, or detention or incarceration can be psychologically traumatic and also can trigger memories and reactions related to previous traumas such as family or community violence or abuse. Young people in the juvenile justice system are at least twice as likely as other youth to have experienced multiple types of psychological trauma in their lives, and as much as [normal]

Therefore, it is essential that juvenile justice residential and community services provide young people with programs that are designed to help them understand and overcome post-traumatic stress disorder (PTSD). A small number of programs have been developed specifically for this purpose (for further information, see Brom, Pat-Horenczyk, and Ford, 2008 and Ford and Blaustein, in review). The trauma-informed intervention that has been most extensively implemented and evaluated to date in juvenile justice systems, Trauma Affect Regulation: Guide for Education and Therapy (TARGET), is the focus of this article.

TARGET was designed to enable youths (and adults who care for and supervise them) to understand how exposure to traumatic stressors can prime the brain and body to react self-protectively on the basis of inborn survival mechanisms. In TARGET, juvenile justice staff and the youths they work with learn how psychological trauma can set off a chain reaction of automatic stress reactions that become PTSD. They also learn that this chain reaction can be stopped, and PTSD can be overcome, by following a straightforward set of steps for resetting body and brain stress ("alarm") systems that require thinking in a more focused way. TARGET thus teaches practical skills for harnessing youths' "brain power" (referred to as "mental focusing") and shows how this can effectively reset the "stress alarm" in their brains. TARGET actually shows adolescents and their families how their brains work and why behavioral and emotional problems often are the result of a brain that is in "survival mode." TARGET then teaches young people a set of easily understood skills for thinking clearly to empower their brains, so that they have control of their emotions and actions rather than being controlled by automatic survival circuits in the brain. When youths (and the adults in their lives, including detention staff and probation officers as well as parents, counselors, teachers, coaches, and employers) learn that there are ways to regain the ability to "stop and think" before becoming too stressed out to be in control of themselves, they often feel motivated to change and, for the first time in a long time, hopeful.

The goal in TARGET is for youths to have more personal control and to be more responsible by recognizing stress reactions before they escalate into aggression, impulsivity, defiance, or addictive self-medication on the one hand, or before they fall into the black hole of depression, avoidance, panic, and isolation on the other hand. Rather than viewing these "symptoms" as missteps that result from unchangeable flaws in their character, personality, upbringing, or peer group, staff members and youths are shown that trauma survivors can regain control over the stress reactions that lead to serious emotional, behavioral, academic, social, and legal problems. This does not provide a justification or excuse for antisocial or dangerous behavior, but instead empowers and challenges youths to take responsibility by thinking in a way that defuses stress reactions and gives them the ability to be in control of their thinking and behavior (rather than just being reactive).

What Does the TARGET Model Involve?

TARGET is a manualized gender-specific intervention that teaches a practical 7-step sequence of skills for processing and managing trauma-related reactions to current stressful experiences (e.g., PTSD

symptoms, traumatic grief, survivor guilt, shame, anger and hostility, interpersonal rejection, and existential/spiritual alienation). The skills are designed in a sequence based on research on the psychobiology of PTSD and complex traumatic stress disorders (see Ford, 2009) and can be delivered in a group format (4 or 10 sessions) or in individual treatment (12 sessions).

The steps are summarized by an acronym ("FREEDOM"): self-regulation via **F**ocusing ("F"); trauma processing via **R**ecognizing current triggers, **E**motions, and cognitive **E**valuations ("REE"), and, strength-based reintegration by **D**efining core goals, identifying currently effective responses (**O**ptions), and affirming core values by **M**aking positive contributions ("DOM").

TARGET also includes a creative arts activity involving personalized "lifelines" which youth make with collage, drawing, poetry, and writing, in order to engage healthy non-traumatic autobiographical memory processing. TARGET's memory re-examination procedures are designed to maximize the survivors' awareness of the present situation, to reduce the risk of rumination, panic, or dissociation, and to enhance the youths' sense of control and safety in titrating memories. Any memory work in TARGET focuses on current or past experiences that have meaning or importance to the youth, not specifically or exclusively on traumatic stressors.

Initial Engagement of Youth and Psychoeducation in Detention

During orientation in detention centers, juveniles are introduced to an explanation for traumatic stress reactions that describes how "normal stress responses" in the brain's alarm, filing center, and thinking center differ from "extreme stress reactions" that are an automatic self-protective adaptation to survive traumatic stressor experiences and that can become chronic problems in the form of PTSD. This novel description of PTSD is used to both explain why sensitive topics (e.g., trauma history, PTSD symptoms, suicide, and alcohol/substance use risk) are being assessed in the screening interview, and how the staff are going to be teaching and helping each youth to use skills for dealing more effectively with stress reactions while in detention. The orientation session also introduces the "Slow Down, Orient, Self-Check" (SOS) skill for mental focusing, in order to provide an immediate practical tool and example of the kinds of self-regulation skills that youths have the opportunity to learn and use while in detention in order to build or strengthen their ability to handle posttraumatic stress reactions without using over-learned "survival coping" tactics such as angry outbursts, reactive or proactive aggression, withdrawal and isolation, dissociation, or somatization.

Psychoeducation Groups in Detention

Within the next two to three days after admission, youths begin participating in TARGET groups with a goal of having each youth complete the first four sessions of TARGET in the first two weeks of their stay. Juveniles who stay longer continue to participate in TARGET group sessions, with the goal of completing as many of the ten TARGET sessions as possible. Staff members use the terminology and skills taught in TARGET groups in all activities (including teachers in the facility's school), in order to reinforce and generalize what youth learn in TARGET groups to their entire daily life. Staff and teachers thus serve as crucial role models not only to encourage youths to use TARGET skills in order to be more self-regulated, but also by demonstrating through their ongoing interactions with young people how those self-regulation concepts and tools can enhance any person's effectiveness. Although designed for a group format with youths in juvenile detention, TARGET has shown evidence of efficacy with delinquent girls in community settings when delivered as a one-to-one therapy and can be done on an individual basis in detention when a group is not feasible.

Staff and Peer Coaching

Two forms of coaching are built into TARGET. Staff members serve as coaches for youths by assisting them in applying the FREEDOM skills in all daily activities, including at positive times as well as in order to manage stress or de-escalate potentially problematic reactions. This provides staff with a way of relating to youths that is educative and empowering, expanding their role from custodial monitoring to guiding youths constructively toward responsible behavior. Staff members have noted that this has made their jobs more satisfying, by enabling them to both help youths do better and to encourage young people in more effective ways.

Peer coaching also is an important TARGET component. Youths who have completed the 4- or 10-session group are included in subsequent groups if they stay longer, so that their focus is on demonstrating their knowledge and being helpful as way to gain respect from peers instead of using deviant behaviors to mask their sense of failure and fear of peer rejection. Youths have proven to be talented teachers and day-to-day reinforcers of TARGET.